NOVA OPTIQUE + EYECARE

Date:

Ms Mr Mrs Dr Name: First Last

Address: Street Apt # DOB

City State Zip SSN (last 4)

Phone: Home Cell Work

Email: Gender (for ins verification) F M

Occupation: Preferred contact method: Phone Text Email

INSURANCE: Vision Medical:

Primary Account Holder (if different) Relationship to patient: Self Parent Spouse Other

Name: First Last

Address: Street DOB

SSN (last 4)

City State Zip

Phone: Home Cell Work

Email: Gender (for ins verification) F M

Medication: List

None

Medication allergies: List

None

Personal ocular history:

- ☐ Laser vision correction
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Retinal hole/tear/detachment
- ☐ Amblyopia (Lazy eye)/Strabismus (eye turn)
- ☐ Diabetic retinopathy
- ☐ Other:

Family ocular history:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Retinal hole/tear/detachment
- ☐ Amblyopia (Lazy eye)/Strabismus (eye turn)
- ☐ Diabetic retinopathy

Other:

Personal medical history:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Pregnant/ Nursing
- ☐ Other

Family medical history:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other

Primary Care Provider:

Name:

Phone:

Fax:

Address:

Social history:	Current	Former	Never
Tobacco use:	☐	☐	☐
Alcohol use:	☐	☐	☐
Cannabis use:	☐	☐	☐
Recreational Drug Use:	☐	☐	☐

How did you find us? Google Other Pt _____

Window/ walked by ZocDoc

Social Media

Other: _____